SERFF Tracking Number:
 UTAC-125786706
 State:
 Arkansas

 Filing Company:
 United Teacher Associates Insurance Company
 State Tracking Number:
 40027

Company Tracking Number: CF96APP-UTA.V2

TOI: H071 Individual Health - Specified Disease - Sub-TOI: H071.002A Dread Disease - Cancer Only

Limited Benefit

Product Name: Cancer Application

Project Name/Number: /

Filing at a Glance

Company: United Teacher Associates Insurance Company

Product Name: Cancer Application SERFF Tr Num: UTAC-125786706 State: ArkansasLH TOI: H07I Individual Health - Specified Disease SERFF Status: Closed State Tr Num: 40027

- Limited Benefit

Sub-TOI: H07I.002A Dread Disease - Cancer Co Tr Num: CF96APP-UTA.V2 State Status: Approved-Closed

Only

Filing Type: Form Co Status: Reviewer(s): Rosalind Minor

Authors: Joyce Kostakis, Melissa

MacLaurin

Date Submitted: 08/25/2008 Disposition Status: Approved-

Closed

Disposition Date: 08/27/2008

Implementation Date Requested: On Approval Implementation Date:

State Filing Description:

General Information

Project Name: Status of Filing in Domicile: Not Filed

Project Number:

Requested Filing Mode:

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Individual

Group Market Size:

Group Market Type:

Filing Status Changed: 08/27/2008

State Status Changed: 08/27/2008 Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

Re: UNITED TEACHER ASSOCIATES INSURANCE COMPANY; NAIC # 63479; FEIN # 58-0869673

NEW POLICY FORM# DESCRIPTION

CF-960201-UTA-APP.V2 Application for First Diagnosis Cancer Benefit

Company Tracking Number: CF96APP-UTA.V2

TOI: H071 Individual Health - Specified Disease - Sub-TOI: H071.002A Dread Disease - Cancer Only

Limited Benefit

Product Name: Cancer Application

Project Name/Number:

CT-95-UTA-APP-V2 Application for Cancer Treatment Benefit

FOR USE WITH APPROVED POLICY:

APPROVED FORM: DESCRIPTION APPROVED

CF-960201-UTA-AR First Diagnosis Cancer Benefit Policy 11/10/1999 CT-950102-UTA-AR Cancer Treatment Benefit Policy 9/24/2004

Dear Analyst,

I am submitting for review and approval the applications described above. We will be using the applications to solicit the Cancer Insurance products referenced above. The Application for First Diagnosis Cancer Benefit will be used with the previously approved First Cancer Benefit Policy. The Application for Cancer Treatment Benefit will be used with the approved Cancer Treatment Policy. The applications are new and are not intended to replace any forms currently in use.

Attached please find a final copy of the applications as well as a statement of variability. The variable fields in the application are dependent on which one of our distribution groups will be marketing the base product. For example, we have a distribution group that markets to seniors only and will not offer the First Diagnosis Heart Attack Rider as the issue ages are limited to ages 0-69. With this distribution group we will remove the First Diagnosis Heart Attack & First Major Heart Surgery Rider from the application. We will use the same application form number, but will reflect the distribution group on the lower right corner of the application such as 08/08 Senior Market. In addition to noting the riders as variable, we have marked the verbiage "these riders" as variable so we can change them to "this rider" when the First Diagnosis Heart Attack rider is removed from the application.

We look forward to your review and approval. Should you have any questions, or need further information, please do not hesitate to contact me at (800) 880-8824 x4794, mmaclaurin@gafri.com or via facsimile at (512) 451-0357. Thank you for your time and consideration with our submission.

Sincerely,

Melissa MacLaurin, Compliance Analyst Compliance Department

 SERFF Tracking Number:
 UTAC-125786706
 State:
 Arkansas

 Filing Company:
 United Teacher Associates Insurance Company
 State Tracking Number:
 40027

Company Tracking Number: CF96APP-UTA.V2

TOI: H071 Individual Health - Specified Disease - Sub-TOI: H071.002A Dread Disease - Cancer Only

Limited Benefit

Product Name: Cancer Application

Project Name/Number: /

Company and Contact

Filing Contact Information

Melissa MacLaurin, mmaclaurin@gafri.com 11200 Lakeline Blvd Ste 100 (512) 807-4794 [Phone]

Austin, TX 78717

Filing Company Information

United Teacher Associates Insurance Company CoCode: 63479 State of Domicile: Texas
11200 Lakeline Blvd., Suite 100 Group Code: 84 Company Type: Insurance

Company

P.O. Box 26580

Austin, TX 78755-0580 Group Name: State ID Number:

(800) 880-8824 ext. [Phone] FEIN Number: 58-0869673

Filing Fees

Fee Required? Yes
Fee Amount: \$40.00
Retaliatory? No

Fee Explanation: \$ 20.00 per form

Per Company: No

COMPANY AMOUNT DATE PROCESSED TRANSACTION #

United Teacher Associates Insurance Company \$40.00 08/25/2008 22103781

Company Tracking Number: CF96APP-UTA.V2

TOI: H071 Individual Health - Specified Disease - Sub-TOI: H071.002A Dread Disease - Cancer Only

Limited Benefit

Product Name: Cancer Application

Project Name/Number:

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-	Rosalind Minor	08/27/2008	08/27/2008

Company Tracking Number: CF96APP-UTA.V2

TOI: H071 Individual Health - Specified Disease - Sub-TOI: H071.002A Dread Disease - Cancer Only

Limited Benefit

Product Name: Cancer Application

Project Name/Number: /

Disposition

Disposition Date: 08/27/2008

Implementation Date: Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

Company Tracking Number: CF96APP-UTA.V2

TOI: H071 Individual Health - Specified Disease - Sub-TOI: H071.002A Dread Disease - Cancer Only

Limited Benefit

Product Name: Cancer Application

Project Name/Number:

Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	STATEMENT OF VARIABILITY	Approved-Closed	Yes
Form	First Diagnosis Cancer Application	Approved-Closed	Yes
Form	Cancer Treatment Application	Approved-Closed	Yes

Company Tracking Number: CF96APP-UTA.V2

TOI: H071 Individual Health - Specified Disease - Sub-TOI: H071.002A Dread Disease - Cancer Only

Limited Benefit

Product Name: Cancer Application

Project Name/Number: /

Form Schedule

Lead Form Number: CF96APP-UTA.V2

Review	Form	Form Type Form Name	Action	Action Specific	Readability	Attachment
Status	Number			Data		
Approved-	CF96APP-	Application/First Diagnosis	Initial			CF96APP-
Closed	UTA.V2	Enrollment Cancer Application				UTA.V2 rev
		Form				08-08.pdf
Approved-	CT95APP-	Application/Cancer Treatment	Initial			CT95APP-
Closed	UTA.V2	Enrollment Application				UTA.V2 rev
		Form				8-08.pdf

UNITED TEACHER ASSOCIATES INSURANCE COMPANY

[P.O. BOX 26580 • AUSTIN, TEXAS 78755-0580]

APPLICATION FOR FIRST DIAGNOSIS CANCER BENEFIT POLICY

			□ Nev	v Busines	s 🗆 Reinsta	tement	□ Benefit	it Change		PV	/ Case#			
County Nan	me:		County 1	Number:		Month	Date of B Day	irth Year	S	ex	Height		W	Veight
Applicant:														
Spouse:											X			X
Child #1:										Full	Time Student	t? 🗆	Yes	□NO
Child #2:										Full	Time Student	t? 🗆	Yes	□NO
Child #3:										Full	Time Student	t?	Yes	□ NO
Applicant's	Address:						City:			State:		Zip Co	de:	
Payer's Nan	ne:		Rela	tionship:			Payer's	Address:						
Applicant's	Social Securit	ty #:					Occupa	tion:						
Beneficiary	(full name):			Relationsh	ip:		Job Dut	ies:						
Employer's	Name:						Employ	er's Addres	s:					
Home teleph	hone # :	()		Work t	telephone #:	()			Best tin	ne to call			
	Individual	☐ Sing	le Parent	t [☐ Family					Pren	nium Payme	ent Mo	de:	
First Diag	gnosis Cano	cer Benefit Po			mount: \$						Modal	Premi	um	\$
□ Intensi	ive Care Ui	nit Benefit Ria	der Be	nefit Am	ount: \$			per day	7		Rider	Premi	um	\$
☐ [Return	n of Premiu	ım Rider]										Premi		\$
□ [First l Rider]	Diagnosis F	Heart Attack &	& First N	Iajor Hed	art Surgery	[]	Benefit A	Amount:]	\$		Rider	Premi	um	\$
□ [Other]	Special Special	fy rider type a	and bene	fit amour	t (if applicable	»:)					Rider	Premi	um	\$
FOR PAY	ROLL DE	DUCTION:												
Group Na	ame:										Enrollmen	nt Fee		\$
Group Nu	umber:		Is	this Secti	ion #125?	☐ Yes	□ No			TO	ΓAL PREM	IIUM		\$
		nce applied for me of Compar				existing in	surance'	?					□ Y	es □ No
	•	MATION. A				le the app	olicable	condition	18.					
	•	ny person to be are other than								-		e result		es □ No
Me PS	elanoma, Ma A levels gre	ny person to lalignant Grow ater than 4.0?	th, Sarco	oma, or a		Cancer, ex	cept nor	-melanor	na ski	n cancer	or had elev	vated	□Y	es □ No
4. Have you or any person to be insured under this policy ever been treated for or had symptoms of Skin Cancer, excluding Melanoma? If Yes, who? Please describe the condition and treatment period.							□Y	es □ No						
Def (Hu	ficiency Syr uman Immu	ny person to b ndrome (AIDS nodeficiency vidual named	S), AIDS Virus "H	Related (IV") bloc	Complex (Alod test? If "Y	RC), or te 'es", who	sted pos	itive on a		S-related			ПΥ	es □ No
	•	ny person to l			his policy ev ase describe				sympt	oms of	Dysplasia o	of the	□Y	es □ No

PLE	EASE ANSWER QUESTIONS #7 & #8 IF YOU ARE APPLYING FOR THE INTENSIVE CARE UNIT BENEFIT RIDER:
7.	Have you or any person to be insured under the Intensive Care Unit Benefit Rider ever been treated for or had symptoms of diabetes or any disorder, abnormality or condition of the brain, lung, liver, or connective tissue? If Yes, who? If the answer is Yes, any individual named will be excluded
	from coverage under this rider.
8.	Are you or any person to be insured under the Intensive Care Unit Benefit Rider currently pregnant? If Yes, who? If the answer is Yes, any individual named will be excluded from coverage under this rider.
PL E	EASE ANSWER QUESTIONS 9–12 IF YOU ARE APPLYING FOR [THE FIRST DIAGNOSIS HEART ATTACK] OR
	E INTENSIVE CARE UNIT BENEFIT RIDER[S]:
9.	Have you or any person to be insured under [these riders] ever had, ever been treated for, or ever had symptoms of, ever received medical advice for, or taken prescribed medication for uncontrolled high blood pressure? If Yes, who? If the answer is Yes, any individual named will be excluded from coverage
10.	under [these riders]. Have you, or any person to be insured under [these riders] ever had or ever been advised to have: any form of heart surgery, coronary artery surgery, or heart related surgery; or an arteriogram, angioplasty, or pacemaker installed, or within the last 6 months, received medical advice or consultation or had medical tests performed (including those during the course of routine check-ups) where the results were other than normal or are still pending? If Yes, who? If the answer is Yes, any individual named will be excluded from coverage under [these riders].
11.	Have you, or any person to be insured under [these riders] ever had, ever been treated for, ever had symptoms of, ever received medical advice for, or ever taken prescribed medication for any disease, disorder or abnormality of the heart or circulatory system (arteries, veins, lymphatic nodes and vessels)? If Yes, who? If the answer is Yes, any individual named will be excluded from coverage under [these riders].
12.	Have you, or any person to be insured under [these riders] ever had, ever been treated for, ever had symptoms of, ever received medical advice for, or ever taken prescribed medication for: myocardial infarction or heart attack, stroke or transient ischemic attack (TIA)? If Yes, who? If the answer if Yes, any individual named will be excluded from coverage under [these riders].
appl cond ackr med Insu the r or to repre there	reby represent that the foregoing answers are recorded as given by me and that the same are true. I represent that all questions on the lication were asked and that the answers were properly recorded. I further agree that this insurance applied for shall be subject to ditions and provisions of the policy and shall not be in force until the application is accepted and the policy issued by the Company mowledge receipt of the Outline of Coverage. I authorize any licensed physician, medical practitioner, hospital, clinic or other medical lically related facility, or The Medical Information Bureau to release any records concerning me or my health to United Teacher Association and its reinsurers. This authorization will be valid for 24 months from the date the authorization is signed. No agent in this application in this application, to pass on insurability, to waive any of the Company's rights or requirement or make or alter any contract. I agree that this application shall form a part of any policy issued. The undersigned applicant and agreement that the applicant has read or had read to him the completed application and he realizes any false statement or misrepresentate the eight which is material to the risk or hazard assumed may result in a loss of coverage under the policy subject to the Time Limit on Cert enses and legal proceedings. A photographic copy of this authorization shall be as valid as the original.
	nderstand that the "Effective Date" of this policy will be the date recorded on the policy schedule by our office. It is not the date dication was signed. The policy has a 30-day "waiting period" which begins on the "Effective Date" of the policy.
APF	NOW THAT ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD AN INSURER SUBMITS A PLICATION FOR INSURANCE CONTAINING FALSE OR DECEPTIVE STATEMENTS MAY BE GUILTY OF SURANCE FRAUD.
	e to Agent: Is replacement of insurance involved? Date:
[Age	ent's Signature
ſΑge	ent's Printed Name ————————————————————————————————————

MEDICARE SUPPLEMENT INSURANCE PRE-AUTHORIZATION AGREEMENT FOR ELECTRONIC FUNDS TRANSFER APPLIES TO:

UNITED TEACHER ASSOCIATES INSURANCE COMPANY - P. O. Box 26580 - Austin, TX 78755-0580

Proposed Insured's Name	Policy Number (if Available)
	Folicy Number (II Available)
Financial Institution Name and Telep	phone Number
Financial Institution Address	
9 Digit Routing Number	Account Number
Requested Withdrawal Date (1st t	hru 28th):
Withdraw Payment: ☐ Monthly	☐ Quarterly ☐ Semi-Annually ☐ Annually
Type of Account: ☐ Personal Checking Account ☐ Personal Savings Account ☐ Corporate/Business Checking Name of Employer Group	Purpose for Submitting this Authorization – Check appropriate box(es): ☐ New authorization ☐ Change in checking/savings account ☐ Change in financial institution ☐ Change in existing coverage
Please tape a VOIDED Check (checking account) or Deposit Slip (savings account) in this box.	TAPE VOIDED CHECK HERE Pay to the order of The Routing number is 9 digits between the **: **: symbols The Routing number is 9 tights between the **: **: symbols **Ithe Routing number is 9 tights between the **: symbols **Ithe Routing number is 9 tights between the **: symbols **Ithe Routing number is 9 tights between the **: symbols **Ithe Routing number is 9 tights between the **: symbols **Ithe Routing number is 9 tights between the **: symbols **Ithe Routing number is 9 tights between the **: symbols **Ithe Routing number is 9 tights between the **: symbols **Ithe Routing number is 9 tights between the **: symbols **Ithe Routing number is 9 tights between the **: symbols **Ithe Routing number is 9 tights between the **: symbols **Ithe Routing number is 9 tights between the **: symbols **Ithe Routing number is 9 tights b

APPLICANT INFORMATION FOR FINANCIAL INSTITUTIONS: As a convenience to me, I hereby request and authorize you to pay and charge to my account, drafts drawn on my account by and payable to the Company selected above provided there are sufficient funds in said account to pay the same on presentation. Such drafts will bear my printed name. This authorization shall remain in effect until revoked by me in writing, and until you actually receive such notice. I agree that you shall be fully protected in honoring any such draft. I agree that your rights in respect to any such draft shall be the same as if it were a check signed personally by me. I further agree that if any such draft is dishonored, whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

PRE-AUTHORIZATION AGREEMENT FOR ELECTRONIC FUNDS TRANSFER

APPLICANT INFORMATION FOR THE COMPANY SELECTED ABOVE: It is understood that the drafts will be drawn on or about the requested date each month. The presentation of such drafts to the above Financial Institution shall constitute notice of premiums being due upon the contract, and no other notice of premiums due will be given. No premium shall be deemed to have been paid unless and until actual payment of the draft drawn for such premium payment has been received by the selected company above. The cancelled draft will constitute receipt of premium payment. The privilege of paying premiums under this Plan may be revoked by the selected company above if any draft is not paid upon presentation. The payment of premiums under this Plan may be terminated by the Contract Owner, Financial Institution Depositor if other than Contract Owner, or by the company selected above upon 30 days written notice.

X		
Print Name of Depositor (as it appears on account)	Signature of Depositor	Date

UNITED TEACHER ASSOCIATES INSURANCE COMPANY

[P.O. BOX 26580 •AUSTIN, TEXAS 78755-0580]

APPLICATION FOR CANCER TREATMENT BENEFIT POLICY

						□ Nev	v Busines	s Reinsta	tement	Benefi	t Change			P	V Case#	ŧ		
County	Name:					County	Number:		Month	Date of Bi	rth Year	Se	ex		Height		V	Veight
Applica					,	County	Tumber.		111011111									
Spouse															X			X
Child #													F	ull Ti	me Studen	nt 🔲	Yes	□ NO
Child #													F	ull Ti	me Studen		Yes	□NO
Child #													F	ull Ti	me Studen	nt 🔲	Yes	□NO
Applica	nt's Address								•	City:			State:			Zip Code	e:	
Payer's	Name:					Rela	ationship:			Payer's	Address:			,			,	
Applica	nt's Social S	ecur	rity#	:						Occupa	tion:							
Benefic	iary (full nan	ne):					Relations	hip:		Job Dut	ies:							
Employ	er's Name:							l l		Employ	er's Addres	ss:						
Home t	elephone #:		()			Work	telephone #:	()			Best t	time 1	to call			
			_		~	_							Dı	romi	iim Davi	ment Mo	da.	
Canca	☐ Indivi	_			Single			☐ Family Benefit Amo	unt: D	to oo	1 \$200 00	, _				al Premi		\$
	read Disea			•	-	Jany .	поѕрцаг	Deliciti Ailio	unt.	90.00 L	1 \$200.00		φ 4 00.	.00		er Premi		\$
	tensive Car					r P	Benefit A	mount: \$			per da	137				er Premi		\$
							CHCIII A	mount. <u>5</u> _			_ per ua	ıy				er Premi		\$
	ancer Scre						Major H	eart Surgery	Ī	Benefit A	ymonut.	\$				er Premi		\$
Rider	_	1313	1160	пты	ιικ α	rust	wiajor iii	euri Surgery	-	2011011111	iiiouiii.	Ψ			_ 100	01 1 101111		Ψ
	turn of Pre	mi	ит Е	Benefit	Rider]									Rid	er Premi	um	\$
□ [Ota	her] S	pec	cify 1	ider ty	pe an	d bene	efit amou	nt (if applicable	e:)						Rid	er Premi	um	\$
	PAYROLL	Di	EDU	CTIO	N:													
Group	Name:															ment Fee		\$
Group	Number:					Is	s this Sec	tion #125?	☐ Ye	s 🔲 No)			TO	TAL PR	EMIUM		\$
						·												
1.	Is the ins If yes, lis							replace any e	xisting ir	isurance'	?						ΙЦ	Yes 🗌 No
MEDI							•	ons and circle	e the ann	licable (ondition	· ·						
							-	this policy e					ancer	ic n	racant w	hara tha	ΙП	Yes 🗆 No
								If Yes, who										100 = 110
3.	Have you	Or	anv	nercon	to be	incur	ed under	this policy e	ver hoon	treated f	for or had	leun	antom	s of	Internal	Cancar		Yes 🗆 No
	•		•					any type of C				•						
	PSA level	s gr	eate	r than 4	1.0?					-								
	If Yes, who? If the answer is Yes, any individual named will be excluded from coverage.																	
4.	Have you	or a	any p	erson	to be i	nsure	d under tl	nis policy eve	r been tre	ated for	or had sy	mpto	oms of	f nor	n-melano	ma		Yes 🗖 No
	skin cance	r?]	If "Y	es", w	ho?		11 "	If th	e answei	r is "Yes	any in	divi	dual n	amo	ed will b	e		
	excluded	ro	m al	I benef	iits pr	ovide	a by the	policy for the	e treatm	ent of m	elanoma	and	skin (cano	er.			
								his policy ev								Immune		Yes 🗖 No
								Complex (Al										
								od test? If "Y					_ 11 t	ne a	nswer is		-	
<u></u>	r es, any i	nal	ıvıdu	ıaı nar	nea W	ш ре	exciuaea	from covera	ıge unae	r uns po	mcy.						1	

6.	Have you or any person to be insured under this policy ever been treated for or had symptoms of Dysplasia of the uterus?Please describe the level diagnosed.	☐ Yes ☐ No
PLE	CASE ANSWER QUESTIONS #7 & #8 IF YOU ARE APPLYING FOR THE INTENSIVE CARE UNIT BENE	FIT RIDER:
7.	Have you or any person to be insured under the Intensive Care Unit Benefit Rider ever been treated for or had symptoms of stroke, heart disease, heart attack or diabetes; or had any other disorder, abnormality or condition of the brain, heart, lung, liver, connective tissue or circulatory system, including the arteries, veins, lymphatic nodes and vessels (but not including high blood pressure, unless controlled? If Yes, who? If the answer is Yes, any individual named will be excluded from coverage under this rider.	☐ Yes ☐ No
8.	Are you or any person to be insured under the Intensive Care Unit Benefit Rider currently pregnant? If Yes, who? If the answer is Yes, any individual named will be excluded from coverage under this rider.	☐ Yes ☐ No
	CASE ANSWER QUESTIONS 9–12 IF YOU ARE APPLYING FOR [THE FIRST DIAGNOSIS HEART A E INTENSIVE CARE UNIT BENEFIT RIDER[S]:	TTACK] OR
9.	Have you or any person to be insured under [these riders] ever had, ever been treated for, or ever had symptoms of, ever received medical advice for, or taken prescribed medication for uncontrolled high blood pressure? If Yes, who If the answer is Yes, any individual named will be excluded from coverage under [these riders].	☐ Yes ☐ No
10.	Have you, or any person to be insured under [these riders] ever had or ever been advised to have: any form of heart surgery, coronary artery surgery, or heart related surgery; or an arteriogram, angioplasty, or pacemaker installed, or within the last 6 months, received medical advice or consultation or had medical tests performed (including those during the course of routine check-ups) where the results were other than normal or are still pending? If Yes, who? If the answer is Yes, any individual named will be excluded from coverage under [these riders].	☐ Yes ☐ No
11.	Have you, or any person to be insured under [these riders] ever had, ever been treated for, ever had symptoms of, ever received medical advice for, or ever taken prescribed medication for any disease, disorder or abnormality of the heart or circulatory system (arteries, veins, lymphatic nodes and vessels)? If Yes, who?	☐ Yes ☐ No
	If the answer is Yes, any individual named will be excluded from coverage under [these riders].	
12.	Have you, or any person to be insured under [these riders] ever had, ever been treated for, ever had symptoms of, ever received medical advice for, or ever taken prescribed medication for: myocardial infarction or heart attack,	☐ Yes ☐ No
	stroke or transient ischemic attack (TIA)? If Yes, who? If the answer if Yes, any	
	individual named will be excluded from coverage under [these riders].	
[PLI RID	EASE ANSWER THE FOLLOWING QUESTION IF YOU ARE APPLYING FOR THE DREAD DISEAS ER:	SE BENEFIT
13.	Have you or any person to be insured under the Dread Disease Benefit Rider ever been treated for or had symptoms of one of the following dread diseases: Addison's Disease, Amyotrophic Lateral Sclerosis, Diphtheria, Encephalitis, Epilepsy, Legionnaire's Disease, Lupus Erythematosus or any connective tissue disorder, Meningitis, Multiple Sclerosis, Muscular Dystrophy, Myasthenia Gravis, Niemann-Pick Disease, Osteomyelitis, Poliomyelitis, Rabies, Reye's Syndrome, Rheumatic Fever, Rocky Mountain Spotted Fever, Scarlet Fever, Sickle Cell Anemia, Smallpox, Tay-Sachs Disease, Tetanus, Toxic Epidermal Necrolysis, Toxic Shock Syndrome, Tuberculosis, Tularemia, Typhoid Fever or Whipple's Disease? If Yes, who?	☐ Yes ☐ No
	For which If the answer is Yes, any individual named will be condition? excluded from this condition under this rider.]	
	•	

I hereby represent that the foregoing answers are recorded as given by me and that the same are true. I represent that all questions on this application were asked and that the answers were properly recorded. I further agree that this insurance applied for shall be subject to the conditions and provisions of the policy and shall not be in force until the application is accepted and the policy issued by the Company. I acknowledge receipt of the Outline of Coverage. I authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, or the Medical Information Bureau to release any records concerning me or my health to United Teacher Associates Insurance Company and its reinsurers. This authorization will be valid for 24 months from the date the authorization is signed. No agent has the right to waive the answer to any question in this application, to pass on insurability, to waive any of the Company's rights or requirements, or to make or alter any contract. I agree that this application shall form a part of any policy issued. The undersigned applicant and agent represent that the applicant has read or had read to him the completed application and he realizes any false statement or misrepresentation therein which is material to the risk or hazard assumed may result in a loss of coverage under the policy subject to the Time Limit on Certain Defenses and legal proceedings. A photographic copy of this authorization shall be as valid as the original.

I KNOW THAT ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD AN INSURER SUBMITS AN APPLICATION FOR INSURANCE CONTAINING FALSE OR DECEPTIVE STATEMENTS MAY BE GUILTY OF INSURANCE FRAUD.

I understand that the "Effective Date" of this policy will be the date recorded on the policy schedule by our office. It is not the date the application was signed. The policy has a 30-day "waiting period" which begins on the "Effective Date" of the policy.

application was signed. The policy has a 30	day ''waiting period'' which begins	on the ''Effective Date'' of the policy.	
Note to Agent: Is replacement of insurance	□ Yes □ No		
Signed at(City and state)	Date:		
[Agent's Signature	Writing Number]	Read and Signed ($$)(Applicant's Signature)	
[Agent's Printed Name	Agent's License Number:	Check Block if Agent Family Business	

MEDICARE SUPPLEMENT INSURANCE PRE-AUTHORIZATION AGREEMENT FOR ELECTRONIC FUNDS TRANSFER APPLIES TO:

UNITED TEACHER ASSOCIATES INSURANCE COMPANY - P. O. Box 26580 - Austin, TX 78755-0580

Proposed Insured's Name	Policy Number (if Available)
Financial Institution Name and Telep	hone Number
Financial Institution Address	
9 Digit Routing Number	Account Number
Requested Withdrawal Date (1st th	ru 28th):
Withdraw Payment: ☐ Monthly	□ Quarterly □ Semi-Annually □ Annually
Type of Account: ☐ Personal Checking Account ☐ Personal Savings Account ☐ Corporate/Business Checking Name of Employer Group	Purpose for Submitting this Authorization – Check appropriate box(es): ☐ New authorization ☐ Change in checking/savings account ☐ Change in financial institution ☐ Change in existing coverage
Please tape a VOIDED Check (checking account) or Deposit Slip (savings account) in this box.	TAPE VOIDED CHECK HERE Pay to the order of The Routing number is 9 digits between the **: ** symbols The Routing number is 9 to the left of in. If check number is should match the number in the upper right corner ** ** ** ** ** ** ** ** **

APPLICANT INFORMATION FOR FINANCIAL INSTITUTIONS: As a convenience to me, I hereby request and authorize you to pay and charge to my account, drafts drawn on my account by and payable to the Company selected above provided there are sufficient funds in said account to pay the same on presentation. Such drafts will bear my printed name. This authorization shall remain in effect until revoked by me in writing, and until you actually receive such notice. I agree that you shall be fully protected in honoring any such draft. I agree that your rights in respect to any such draft shall be the same as if it were a check signed personally by me. I further agree that if any such draft is dishonored, whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

PRE-AUTHORIZATION AGREEMENT FOR ELECTRONIC FUNDS TRANSFER

APPLICANT INFORMATION FOR THE COMPANY SELECTED ABOVE: It is understood that the drafts will be drawn on or about the requested date each month. The presentation of such drafts to the above Financial Institution shall constitute notice of premiums being due upon the contract, and no other notice of premiums due will be given. No premium shall be deemed to have been paid unless and until actual payment of the draft drawn for such premium payment has been received by the selected company above. The cancelled draft will constitute receipt of premium payment. The privilege of paying premiums under this Plan may be revoked by the selected company above if any draft is not paid upon presentation. The payment of premiums under this Plan may be terminated by the Contract Owner, Financial Institution Depositor if other than Contract Owner, or by the company selected above upon 30 days written notice.

X		
Print Name of Depositor (as it appears on account)	Signature of Depositor	Date

Company Tracking Number: CF96APP-UTA.V2

TOI: H071 Individual Health - Specified Disease - Sub-TOI: H071.002A Dread Disease - Cancer Only

Limited Benefit

Product Name: Cancer Application

Project Name/Number: /

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number: UTAC-125786706 State: Arkansas

Filing Company: United Teacher Associates Insurance Company State Tracking Number: 40027

Company Tracking Number: CF96APP-UTA.V2

TOI: H071 Individual Health - Specified Disease - Sub-TOI: H071.002A Dread Disease - Cancer Only

Limited Benefit

Product Name: Cancer Application

Project Name/Number:

Supporting Document Schedules

Review Status:

Satisfied -Name: Certification/Notice Approved-Closed 08/27/2008

Comments: Attachment:

AR Certification.pdf

Review Status:

Bypassed -Name: Application Approved-Closed 08/27/2008

Bypass Reason: SEE FORM SCHEDULE TAB

Comments:

Review Status:

Bypassed -Name: Health - Actuarial Justification Approved-Closed 08/27/2008

Bypass Reason: N/A

Comments:

Review Status:

Bypassed -Name: Outline of Coverage Approved-Closed 08/27/2008

Bypass Reason: N/A

Comments:

Review Status:

Satisfied -Name: STATEMENT OF VARIABILITY Approved-Closed 08/27/2008

Comments:

Attachments:

Cancer First Application statement of variable data.pdf

Cancer Treatment Application statement of variable data.pdf

Arkansas Certification

This	submission	meet	ts the	provisions	of	Rule	and	l Regulatio	n 19,	"Unfair	sex
discri	mination in	the s	ale of	insurance"	as v	well as	all	applicable	require	ments of	this
Depa	rtment.										

Melina Madaumi	, Compliance Analyst	August 21, 2008
Name and Title		Date

STATEMENT OF VARIABLE DATA UNITED TEACHER ASSOCIATES INSURANCE COMPANY

[P.O. BOX 26580 • AUSTIN, TEXAS 78755-0580]

APPLICATION FOR FIRST DIAGNOSIS CANCER BENEFIT POLICY

PV Case#

☐ New Business ☐ Reinstatement ☐ Benefit Change

Comment [m1]: Address is variable should the company change addresses in the future.

							Date of Birth				TT : 1.		.,	
County Name:			Co	unty Number:		Month	Day Ye	ar	Sex		Height		v	Veight
Applicant:														
Spouse:											X			X
Child #1:										Full Ti	me Studer	nt?	Yes	□NO
Child #2:										Full Ti	me Studer		☐ Yes	
Child #3:										Full Ti	me Studer	T	☐ Yes	□ NO
Applicant's Addre	ess:						City:		Stat	te:		Zip C	ode:	
Payer's Name: Relationship: Payer's Address:														
Applicant's Social Security #: Occupation:														
Beneficiary (full n	name):			Relationsl	nip:		Job Duties:							
Employer's Name	::			·	·		Employer's	Address:						
Home telephone #	ŧ:	()		Work	telephone # :	()		В	est time t	o call			
□ Indi	vidual	□s	ingle P	arent	☐ Family					Premiu	m Paym	nent M	lode:	
First Diagnosi	s Canc	er Benefi	t Policy	Benefit A	mount: \$						Moda	ıl Pren	nium	\$
☐ [Intensive (Care U	nit Benefii	t Rider)	Benefit A	mount: \$		ŗ	er day			Ride	r Pren	nium	\$
☐ [Return of I	Premiu	m Rider]									Ride	er Pren	nium	\$
☐ [First Diago Rider]	nosis H	leart Attac	ck & Fi	rst Major He	art Surgery	[]	Benefit Am	ount:]	\$		Ride	r Pren	nium	\$
□ Other	Specif	y rider typ	e and l	benefit amour	nt (if applicable	::)					Ride	r Pren	nium	\$
FOR PAYROL	L DEI	DUCTION	V:											
Group Name:										Е	Inrollme	ent Fee	,	\$
Group Numbe	er:			Is this Sect	ion #125?	Yes	□ No			TOTA	L PRE	MIUM	[\$
1. Is the i	nsuran	ce applied	for her	e intended to	replace any e	existing in	surance?	<u> </u>						res □ No
				nd policy nun										
MEDICAL IN 2. Have vo				v er all questi c sured under th						recent :	syboro th	20 2 001	1to	
		• 1		mal? If Yes,		i iiau a te		lease de				ie resu		res □ No
						ver been	treated for	or had s	vmnton	s of Int	ternal C	ancer	ПУ	'es □ No
3. Have you or any person to be insured under this policy ever been treated for or had symptoms of Internal Cancer, ☐ Yes ☐ No Melanoma, Malignant Growth, Sarcoma, or any type of Cancer, except non-melanoma skin cancer or had elevated														
PSA levels greater than 4.0?														
If Yes, who? If the answer is Yes, any individual named will be excluded from coverage.														
4. Have yo	ou or an	y person t	o be ins	sured under th	is policy eve	r been tre	ated for or l	had sym	ptoms o	f Skin	Cancer.		□Y	es □ No
excludin	ng Mela	noma?	If Yes				Please d							
treatme	treatment period.													
5. Have you or any person to be insured under this policy ever been treated for or had symptoms of Acquired Immune \(\subseteq \text{Yes} \subseteq No \)														
Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or tested positive on an AIDS-related														
(Human Immunodeficiency Virus "HIV") blood test? If "Yes", who? If the answer is Yes, any individual named will be excluded from coverage under this policy.														
105, 411	res, any murvious named with the executed from coverage under this poncy.													

CF96APP-UTA.V2 08/08

Comment [m2]: Riders are described as variable as we may elect not to offer a rider in the future. We will not add any riders that are not described in this application.

symptoms of diabetes or any disorder, abnormality or condition of the brain, lung, liver, or connective tissue? If Yes, who? If the answer is Yes, any individual named will be excluded from coverage under this rider. 8. Are you or any person to be insured under the Intensive Care Unit Benefit Rider currently pregnant? If Yes, who?	. —
	es 🗆 No
If the answer is Yes, any individual named will be excluded from coverage under this rider.	es □ No
PLEASE ANSWER QUESTIONS 9–12 IF YOU ARE APPLYING FOR [THE FIRST DIAGNOSIS HEART ATTACK] THE INTENSIVE CARE UNIT BENEFIT RIDER[S]:	OR
9. Have you or any person to be insured under [these riders] ever had, ever been treated for, or ever had symptoms of, ever received medical advice for, or taken prescribed medication for uncontrolled high blood pressure? If Yes, who? If the answer is Yes, any individual named will be excluded from coverage	es 🗆 No
under [these riders]. 10. Have you, or any person to be insured under [these riders] ever had or ever been advised to have: any form of heart surgery, coronary artery surgery, or heart related surgery; or an arteriogram, angioplasty, or pacemaker installed, or within the last 6 months, received medical advice or consultation or had medical tests performed (including those during the course of routine check-ups) where the results were other than normal or are still pending? If Yes, who? If the answer is Yes, any individual named will be excluded from coverage under [these riders].	es 🗆 No
11. Have you, or any person to be insured under [these riders] ever had, ever been treated for, ever had symptoms of, ever received medical advice for, or ever taken prescribed medication for any disease, disorder or abnormality of the heart or circulatory system (arteries, veins, lymphatic nodes and vessels)? If Yes, who? If the answer is Yes, any individual named will be excluded from coverage under [these riders].	es 🗆 No
12. Have you, or any person to be insured under [these riders] ever had, ever been treated for, ever had symptoms of, ever received medical advice for, or ever taken prescribed medication for: myocardial infarction or heart attack, stroke or transient ischemic attack (TIA)? If Yes, who? If the answer if Yes, any individual named will be excluded from coverage under [these riders]	es 🗆 No
I hereby represent that the foregoing answers are recorded as given by me and that the same are true. I represent that all questic application were asked and that the answers were properly recorded. I further agree that this insurance applied for shall be subconditions and provisions of the policy and shall not be in force until the application is accepted and the policy issued by the Cacknowledge receipt of the Outline of Coverage. I authorize any licensed physician, medical practitioner, hospital, clinic or other medically related facility, or The Medical Information Bureau to release any records concerning me or my health to Unite Associates Insurance Company and its reinsurers. This authorization will be valid for 24 months from the date the authorization No agent has the right to waive the answer to any question in this application, to pass on insurability, to waive any of the Comparor requirements, or to make or alter any contract. I agree that this application shall form a part of any policy issued. The unapplicant and agent represent that the applicant has read or had read to him the completed application and he realizes any false st misrepresentation therein which is material to the risk or hazard assumed may result in a loss of coverage under the policy subtime Limit on Certain Defenses and legal proceedings. A photographic copy of this authorization shall be as valid as the original	opject to the Company. I medical or ded Teacher a is signed. any's rights indersigned attement or opject to the
I understand that the "Effective Date" of this policy will be the date recorded on the policy schedule by our office. It is not the application was signed. The policy has a 30-day "waiting period" which begins on the "Effective Date" of the policy.	re date the
I KNOW THAT ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD AN INSURER SUBJAPPLICATION FOR INSURANCE CONTAINING FALSE OR DECEPTIVE STATEMENTS MAY BE GUINSURANCE FRAUD.	
Note to Agent: Is replacement of insurance involved? Signed at Date:	10
(City and state) [Agent's Signature Writing Number 1 Read and Signed (√)	

Comment [m3]: If the First Diagnosis Heart Attack rider is removed, we will remove the rider from this question and make the word riders singular.

Comment [m4]: If he First Diagnosis Heart Attack rider is removed this variable will become this rider instead of these riders.

Comment [m5]: If he First Diagnosis Heart Attack rider is removed this variable will become this rider instead of these riders.

Comment [m6]: If he First Diagnosis Heart Attack rider is removed this variable will become this rider instead of these riders.

Comment [m7]: If he First Diagnosis Heart Attack rider is removed this variable will become this rider instead of these riders.

[Agent's Printed Agent's License Number: Check Block if Agent Family Business Name

(Applicant's Signature)

Check Block if Agent Family Business

Comment [m8]: The agent information is variable so it can be removed on the direct mail application where no agent is involved.

STATEMENT OF VARIABLE DATA UNITED TEACHER ASSOCIATES INSURANCE COMPANY

[P.O. BOX 26580 •AUSTIN, TEXAS 78755-0580]

APPLICATION FOR CANCER TREATMENT BENEFIT POLICY

Comment [m1]: Address is variable should the company change addresses in the future.

		New Business	☐ Reinstat	tement [Benefit	Change			PV Case#	#	
County Name:	Cou	unty Number:		Month I	Date of Birtl Day	h Year	Sex		Height		Weight
Applicant:		"									
Spouse:									X		X
Child #1:								Full	Time Studer	nt 🔲	Yes NO
Child #2:								Full	Time Studer	nt 🗆	Yes NO
Child #3:								Full	Time Studer	nt 🔲	Yes NO
Applicant's Address:					City:		S	tate:		Zip Cod	le:
Payer's Name: Relationship: Payer's Address:											
Applicant's Social Security #: Occupation:											
Beneficiary (full name):		Relationship	o:		Job Dutie	es:					
Employer's Name:					Employer	's Addres	s:				
Home telephone #:)	Work tel	lephone #:	()			Best tin	e to call		
☐ Individual	☐ Single Pa	arent	Family					Prei	nium Payı	ment Mo	ode:
Cancer Treatment Ben				unt: 🗆 \$	0.00	\$200.00	□\$	400.00) Mod	lal Prem	ium \$
☐ [Dread Disease Ben	efit Rider]								Rid	ler Prem	ium \$
☐ [Intensive Care Uni	t Benefit Rider]	Benefit Ar	nount: \$_			per da	y		Rid	ler Prem	ium \$
☐ [Cancer Screening I	Benefit Rider]								Rid	ler Prem	ium \$
☐ [First Diagnosis Heal	art Attack & Fi	rst Major Hear	rt Surgery	В	enefit Aı	nount:	\$		Rid	ler Prem	ium \$
☐ [Return of Premium]	Benefit Rider]	1							Rid	ler Prem	ium_\$
☐ Other Specify	rider type and b	enefit amount	(if applicable	e:)					Rid	ler Prem	ium \$
FOR PAYROLL DEDU	UCTION:										
Group Name:									Enroll	ment Fe	e \$
Group Number:		Is this Section	on #125?	☐ Yes	□ No			T	OTAL PR	REMIUM	1 \$
Is the insurance	applied for here	intended to re	place any e	xisting in	surance?						☐ Yes ☐ No
If yes, list name	of Company an	d policy number	er:								
MEDICAL INFORMA		-									
2. Have you or any results are pending											
2	naman ta ha in	ound and the	ia maliare a		tunatad fa	اد ما سه س			of Intomol	Comoon	☐ Yes ☐ No
Melanoma, Malignant Growth, Sarcoma, or any type of Cancer, except non-melanoma skin cancer, or had elevated									,		
PSA levels greate If Yes, who?		If the answ	ver is Yes,	any indiv	idual na	med wil	l be e	xclude	d from co	verage.	
4. Have you or any											☐ Yes ☐ No
skin cancer? If "Y excluded from a										e	
5. Have you or any	person to be ins	sured under this	s policy ev	er been tr	eated for	or had s	ympt	oms of	Acquired	Immune	Yes 🗆 No
Deficiency Syndr (Human Immuno	. ,,		Ι '	,,			ı AID		ed answer is		
(11611MII IIIIIIIIIIII	actionity vitua	, 111 +) 0100u		55 , WHO:							

Comment [m2]: Riders are described as variable as we may elect not to offer a rider in the future. We will not add any riders that are not described in this application.

	Yes, any individual named will be excluded from coverage under this policy.		
6.	Have you or any person to be insured under this policy ever been treated for or had symptoms of Dysplasia of the uterus?Please describe the level diagnosed.	Yes No	
PLE	ASE ANSWER QUESTIONS #7 & #8 IF YOU ARE APPLYING FOR THE INTENSIVE CARE UNIT BENEI	FIT RIDER:	
7.	Have you or any person to be insured under the Intensive Care Unit Benefit Rider ever been treated for or had symptoms of stroke, heart disease, heart attack or diabetes; or had any other disorder, abnormality or condition of the brain, heart, lung, liver, connective tissue or circulatory system, including the arteries, veins, lymphatic nodes and vessels (but not including high blood pressure, unless controlled? If Yes, who?	Yes No	
8.	Are you or any person to be insured under the Intensive Care Unit Benefit Rider currently pregnant? If Yes, who? If the answer is Yes, any individual named will be excluded from coverage under this rider.	☐ Yes ☐ No	
	ASE ANSWER QUESTIONS 9–12 IF YOU ARE APPLYING FOR THE FIRST DIAGNOSIS HEART A INTENSIVE CARE UNIT BENEFIT RIDER S :	TTACK] OR	 Comment [m3]: If the First Diagnosis Heart
9.	Have you or any person to be insured under [these riders] ever had, ever been treated for, or ever had symptoms of, ever received medical advice for, or taken prescribed medication for uncontrolled high blood pressure? If Yes, who If the answer is Yes, any individual named will be excluded from coverage under [these riders].	☐ Yes ☐ No	 Attack rider is removed, we will remove the rider from this question and make the word riders singular Comment [m4]: If the First Diagnosis Heart
10.	Have you, or any person to be insured under [these riders] ever had or ever been advised to have: any form of heart surgery, coronary artery surgery, or heart related surgery; or an arteriogram, angioplasty, or pacemaker installed, or within the last 6 months, received medical advice or consultation or had medical tests performed (including those during the course of routine check-ups) where the results were other than normal or are still pending? If Yes, who? If the answer is Yes, any individual named will be excluded from coverage	□ Yes □ No	 Attack rider is removed this variable will become this rider instead of these riders. Comment [m5]: If the First Diagnosis Heart
11.	under [these riders]. Have you, or any person to be insured under [these riders] ever had, ever been treated for, ever had symptoms of, ever received medical advice for, or ever taken prescribed medication for any disease, disorder or abnormality of the heart or circulatory system (arteries, veins, lymphatic nodes and vessels)? If Yes, who?	☐ Yes ☐ No	 Attack rider is removed this variable will become this rider instead of these riders.
12.	If the answer is Yes, any individual named will be excluded from coverage under [these riders]. Have you, or any person to be insured under [these riders] ever had, ever been treated for, ever had symptoms		 Comment [m6]: If the First Diagnosis Heart Attack rider is removed this variable will become this rider instead of these riders.
12.	of, ever received medical advice for, or ever taken prescribed medication for: myocardial infarction or heart attack,	_ 163 110	
(DI I	stroke or transient ischemic attack (TIA)? If Yes, who? If the answer if Yes, any individual named will be excluded from coverage under [these riders] CASE ANSWER THE FOLLOWING QUESTION IF YOU ARE APPLYING FOR THE DREAD DISEAS	E DENEEIT	 Comment [m7]: If the First Diagnosis Heart Attack rider is removed this variable will become this rider instead of these riders.
RID		E BENEFII	
13.	Have you or any person to be insured under the Dread Disease Benefit Rider ever been treated for or had symptoms of one of the following dread diseases: Addison's Disease, Amyotrophic Lateral Sclerosis, Diphtheria, Encephalitis, Epilepsy, Legionnaire's Disease, Lupus Erythematosus or any connective tissue disorder, Meningitis, Multiple Sclerosis, Muscular Dystrophy, Myasthenia Gravis, Niemann-Pick Disease, Osteomyelitis, Poliomyelitis, Rabies, Reye's Syndrome, Rheumatic Fever, Rocky Mountain Spotted Fever, Scarlet Fever, Sickle Cell Anemia, Smallpox, Tay-Sachs Disease, Tetanus, Toxic Epidermal Necrolysis, Toxic Shock Syndrome, Tuberculosis, Tularemia, Typhoid Fever or Whipple's Disease? If Yes, who?	□ Yes □ No	
	For which If the answer is Yes, any individual named will be condition?		 Comment [m8]: If the Dread Disease Rider is
	excluded from this condition under this rider.]		removed, this question will also be removed.

I hereby represent that the foregoing answers are recorded as given by me and that the same are true. I represent that all questions on this application were asked and that the answers were properly recorded. I further agree that this insurance applied for shall be subject to the conditions and provisions of the policy and shall not be in force until the application is accepted and the policy issued by the Company. I acknowledge receipt of the Outline of Coverage. I authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, or the Medical Information Bureau to release any records concerning me or my health to United Teacher Associates Insurance Company and its reinsurers. This authorization will be valid for 24 months from the date the authorization is signed. No agent has the right to waive the answer to any question in this application, to pass on insurability, to waive any of the Company's rights or requirements, or to make or alter any contract. I agree that this application shall form a part of any policy issued. The undersigned applicant and agent represent that the applicant has read or had read to him the completed application and he realizes any false statement or misrepresentation therein which is material to the risk or hazard assumed may result in a loss of coverage under the policy subject to the Time Limit on Certain Defenses and legal proceedings. A photographic copy of this authorization shall be as valid as the original.

I KNOW THAT ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD AN INSURER SUBMITS AN APPLICATION FOR INSURANCE CONTAINING FALSE OR DECEPTIVE STATEMENTS MAY BE GUILTY OF INSURANCE FRAUD.

I understand that the "Effective Date" of this policy will be the date recorded on the policy schedule by our office. It is not the date the application was signed. The policy has a 30-day "waiting period" which begins on the "Effective Date" of the policy.

Note to Agent: Is replacement of insurance involved? □ Yes □ No									
Signed at(City and state)	Date:								
[Agent's Signature	Writing Number]	Read and Signed (\(\sqrt{)}\)							
		(Applicant's Signature)							
[Agent's Printed Name	Agent's License Number:	Check Block if Agent Family Business □							

Comment [m9]: We will remove the agent signature for direct mail

Comment [m10]: We will remove the agent data for direct mail applications